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April 24, 2007

MEMORANDUM

TO: Legislative Oversight Committee
Commission for MH/DD/SAS
Local CFAC Chairs
State CFAC
NC Council of Community Programs
NC Assoc. of County Commissioners
County Managers
County Board Charis
State Facility Directors
LME Directors
LME Board Chairs
DHHS Division Directors
Advocacy Organizations
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations
NC Association of County DSS Directors

FROM: Allen Dobson, MD
Mike Moseley

SUBJECT: Implementation Update #27: Revised Community Support Authorization Criteria and Utilization Review

The Division of Medical Assistance, ValueOptions and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services have concluded their review of the community support definition and authorization criteria as announced in a February 7, 2007, memo from Secretary Carmen Hooker Odom. The recommendations were presented to the following stakeholder groups: the MH/DD/SA External Advisory Group, the State Consumer and Family Advisory Committee, the NC Providers Council, the NC Council of Community Programs and the Provider Relations Leadership Forum (PRLF). We are now engaged in the final steps needed to implement these changes as of early June 2007.

The Department will continue to review and monitor the utilization of community support services to ensure that recipients are getting the treatment they need. As the authorization steps

are implemented and data is reviewed, the Department will further refine and modify the plan on a quarterly basis.

The revised utilization plan includes:

1. The Department and the Local Management Entities (LMEs) will conduct post-payment reviews of all current and new recipients of community support who are receiving community support in excess of an average of 12 hours per week. These reviews, which will be triggered by authorization data and paid claims data maintained by the Department, will begin May 1, 2007. Each review will result in one of the following four determinations:
    - The recipient is receiving the appropriate clinical intervention and treatment.
    - Based upon clinical peer review, the recipient's person-centered plan and treatment options require additional review for determination of appropriate treatment options.
    - The provider requires training regarding the use of community support and/or treatment planning.
    - The provider will be referred to DMA for further review and investigation.

    Any recommended changes in the recipient's treatment plan will be made through the local treatment team. Changes will be subject to ValueOptions review and approval. Recipients whose community support services are reduced, terminated or denied will be notified of their Medicaid appeal rights.

2. Attached are the revised community support authorization procedures and criteria that will be used by ValueOptions to serve adult and child recipients.
    a. Effective immediately, ValueOptions will flag for further clinical review any requests for increase of hours for Community Support. As a result of the review, ValueOptions will recommend the most clinically appropriate service, if other than community support, as clinically supported, offering transition activities as clinically needed.
    b. DMA Clinical Coverage Policy No. 8A, Enhanced Mental Health and Substance Abuse Services, will be modified to incorporate the refined authorization criteria and limitations as outlined in the attachments. Effective date for policy change will be June 11, 2007.

With this revised utilization plan, along with the ongoing audits of medical records and the implementation of the revised community support provider endorsement checklists, DHHS believes we are moving forward with assurance that the Community Support service will be provided in accordance to the service definition, in the appropriate amounts to meet the needs of the appropriate subset of recipients.

CC: Secretary Carmen Hooker Odom
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Community Support Services for Adults

Entry process into Community Support services:

- No 30-day pass-through period
- Unmanaged initial 8 qualified professional hours for collection of information to develop and initiate the person-centered plan (PCP)
- Must have relevant diagnostic information to complete the PCP, which may be fulfilled through a Diagnostic Assessment or recent Diagnosis information
- No additional Community Support (CS) services can be requested without a complete PCP with signatures & an ITR
- The qualified professional (QP) should link the consumer to an alternate service within the 8 hours; this should be reflected in the PCP & ITR submitted to ValueOptions (VO)

Review of the initial person-centered plan:

- VO will evaluate medical necessity to determine if more or less intensive services are required
- Initial benefit may be authorized up to 780 units for a 90-day period based upon judgment of PCP and supporting documentation submitted

Continuation requests:

- If 780 units or the amount authorized are authorized and completely expended before the 90 days, then a new ITR and updated PCP should be submitted to VO to request alternate services. The revision of the PCP is required because the client's needs were not adequately reflected in the initial PCP based upon service utilization. Additional units may be authorized for QP coordination of these alternate services on a time-limited basis.
- If continued CS services are needed at the end of the 90 day authorization, then a new ITR and updated PCP should be submitted to VO.
- Clients currently receiving CS services will have a change to their authorization or benefit at the time the current authorization expires. It is incumbent upon the current CS provider to make referrals for differing levels of treatment if the revised CS benefit is inadequate to meet the client's needs. To ensure effective continuity of care, this should occur as soon as possible and at least 30 days before the CS authorization expires.
- The continuation requests for CS must be accompanied by an updated PCP and ITR that reflect the appropriate level of care and service.
- CS at the level of 780 units per 90 days is not intended to be a long-term service. Continued requests beyond the first 6 months will require significant justification.
- Authorization for CS hours at a lower level beyond 6 months may be requested in order to meet the functions of clinical home and case management.

Community Support Services for Children

Revised entry process into Community Support services:

- No 30-day pass-through period
- Unmanaged initial 8 QP hours for collection of information to initiate the Person Centered Plan
- Must have diagnostic information for submission of the ITR, which may be fulfilled through a Diagnostic Assessment or recent Diagnosisinformation. This information should reflect medical necessity "to correct or ameliorate a defect, physical or mental illness or a condition [health problem] diagnosed by the recipient's physician, therapist or other licensed practitioner" to be reviewed under EPSDT criteria.
- The QP may link the consumer to an alternate service within the 8 hours; this should be reflected in the information submitted to VO.

Review of the initial prior authorization request:

- If the needed medical information is not complete when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. In an effort to ensure the delivery of needed services, interim prior authorization with variable timelines for resubmission will be granted.
- VO will evaluate medical necessity to determine if more or less intensive services are required. "Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment." Every case will be reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.
- Medically necessary service will be authorized "in the most economic mode, as long as the treatment made available is similarly efficacious to services requested by the recipient's physician, therapist or other licensed practitioner."
- The initial prior authorization will cover a period not to exceed 90 days.

Continuation requests:

- To ensure effective continuity of care, this should occur at least 30 days before the CS authorization expires.
- The continuation requests for CS should be accompanied by an updated PCP and ITR that reflect the appropriate level of care and service.